GS-602
and 680

SUPPLEMENTAL QUALIFICATIONS STATEMENT
Medical and Dental Officer, GS-11/15

Form approved
OMB No. 50-R0481

(Complete And Submit this Form with your Personal Qualifications Statement, SF-171)

If more space is required, use plain paper. Write your name on each sheet and attach to this form.

1. Name (Last, First, Middle)	2. Birth Date (Month, Day, Year)	3. Social Security Number
4. Address (Number, Street, City, State, Zip Code)	5. Basic Professional Training (Name and Location of School)	
	6. Type of Degree (e.g., M.D.) and Date Received (Month, Day, Year)	7. Class Rank or Standing Top _____ %
8. If your degree was received in a school outside of the U.S., have you passed the examination given by the Education Council for Foreign Medical Graduates? Yes ☐ No ☐	9. Date of ECFMS Certificate, if applicable (Month, Day, Year)	

10. INTERNSHIP

Type of Internship and Specialty	Name and Location of Hospital (City and State)	Name of Chief of Service or Program Director	Dates Attended (Month/Year) From	Dates Attended (Month/Year) To	Date Certificate Received

11. RESIDENCY TRAINING AND FELLOWSHIP

Name of Specialty	Name and Location of Hospital (City and State)	Name of Chief of Service or Program Director	Dates Attended (Month/Year) From	Dates Attended (Month/Year) To	Date Certificate Received

12. OTHER GRADUATE EDUCATION

Major Field of Study or Program	Name and Location of Hospital (City and State)	Certificate, Diploma, or Degree Received and Date (Mo./Yr.)	Dates Attended (Month/Year) From	Dates Attended (Month/Year) To

13. CERTIFICATION BY A SPECIALTY BOARD

A. Are you eligible for certification by an American Specialty Board?	Yes		No		
B. Are you Board certified?	Yes		No		

C. If your answer to A or B is "Yes," furnish the following:

1. Name of Specialty Board	2. Specialty	3. Date of Certification or Eligibility (Month/Yr.)

14. PRIVATE PRACTICE EXPERIENCE

Type of Practice	Location (City and State)	From (Month/Year)	To (Month/Year)
A. General Practice			
B. Specialized Practice (Specify Specialty)			
C. Give a Brief Description of the Nature of Your Practice:			

15. PERSONAL QUALIFICATIONS AND SCIENTIFIC CONTRIBUTIONS

A. Professional or scientific societies with which Affiliated (Do Not Abbreviate)	Type of Membership	Official Posts Held

B. Scholarships, honors, citations, awards, or other professional recognition received.

C. Seminars, important professional committees, and panels conducted. (Cite pertinent examples.)

D. Service as a consultant? If so, give information as to specialties, to whom, purpose, frequency, length and recency.

E. Articles, books, reports, and papers published. Papers presented before professional groups. Start with earliest publication or paper presented and group in successive five-year periods. If material has been published in professional journals, give names of journals and dates of issue. (Do not list abstracts and do not submit copies of publications or papers unless requested to do so.)

16. EXPERIENCE IN HOSPITALS, CLINICS, OR OTHER MEDICAL OR DENTAL ACTIVITY CARE PROGRAMS

(Indicate paid experience other than internships, residencies, and fellowships.)

Name and Location of Hospital, Clinic, or Other Program (City and State)	Name of Chief of Service or Program Director	Dates (Month/Year) From	To	Brief Statement of Duties

17. RESEARCH

Name and Location of Hospital or Other Institution (City and State)	Research Projects (Title and Nature)	Name of Supervisor or Project Director	Dates (Month/Year)		State Whether you Directed the Research, Conducted the Projects, or served as an Assistant
			From	To	

18. FOR DENTAL OFFICER APPLICANTS ONLY

A. If you are thoroughly familiar with the subjects listed below and are capable of performing the operation independent of supervision, signify by marking "X" in the box in front of the item.
If you have performed the operation under supervision and feel such supervision is desirable, signify by marking an 'O' in the box in front of the item. If you have never performed the operation, leave the box blank in front of the item.

- ☐ Recording a complete oral examination by use of mouth mirror and explorer, interpretation of Dental Radiographs, Transillumination, and Vitalo meter
- ☐ Interpretation of Dental Radiographs
- ☐ Use of Dental X-ray unit and processing of films
- ☐ Oral Prophylaxis
- ☐ Black's and other approved cavity preparations (all classifications)
- ☐ Use of Silicate (porcelain) cement
- ☐ Use of plastic filling materials
- ☐ Insertion of contoured Amalgram restoration
- ☐ Construction and insertion of gold inlay (direct or indirect method)
- ☐ Construction and insertion of three-quarter crown
- ☐ Construction of gold crown (sectional or cast)
- ☐ Insertion of gold foil filling
- ☐ Preparation of jacket crown
- ☐ Construction of fixed partial dentures
  - ☐ Compound only
  - ☐ Compound in connection with other material
- ☐ Hydrocolloid compound impressions of partially edentulous mouth
- ☐ Taking the 'bite'
- ☐ Obtaining the inter-occlusal relationship
- ☐ Boxing impression and casting model with artificial stone
- ☐ Construction of contour occlusion rims:
  - ☐ In wax
  - ☐ In compound
  - ☐ Of resin material
- ☐ Setting up artificial teeth (anatomical articulation)
- ☐ Designing removable oral prosthesis with particular reference to location and design of clasps, rests and major connectors
- ☐ Construction of removable oral prosthesis
- ☐ Proper manipulation of plasters, investment and artificial stone
- ☐ Capable of performing laboratory procedures in construction of:
  - ☐ Complete dentures
  - ☐ Removable dentures
  - ☐ Casting inlays and crowns
  - ☐ Fixed partial dentures
- ☐ Local anesthesia (infiltrative and conductive)
- ☐ Extraction of teeth
- ☐ Alveolectomy
- ☐ Reduction and fixation of fractures of Mandible and Maxilla:
  - ☐ Intermaxillary wiring
  - ☐ By cast metal or plastic splints
  - ☐ By intra- or extra-oral mechanical splints (in edentulous cases)
  - ☐ By open reduction oral mechanical splints (in edentulous cases)
  - ☐ Surgical removal of impacted teeth
  - ☐ Surgical removal of cyst

B. Would you accept a position which includes the treatment of children? ☐ Yes ☐ No

Answer Items 19 and 20 by placing an "X" in the proper column.	**Yes**	**No**
19. Are you currently licensed to practice medicine and surgery or dentistry in a State or Territory of the United States? If "Yes," specify the State or Territory.		
20. Are you registered under the Anti-Narcotic (Harrison) Act? Specify the State or Territory.		
Answer Items 21 through 23 by placing an "X" in the proper column. If any answer is "YES," please explain fully in Item 24.		
21. A. Is your license to practice medicine and surgery or dentistry limited or restricted (e.g., use of drugs, use of surgery, etc.) in any way?		
B. Is your license temporary?		
22. A. Has your license to practice medicine and surgery or dentistry ever been suspended or revoked?		
B. Has your application for adminission to a state or territorial licensing examination for the practice of medicine and surgery or dentistry ever been refused?		
C.Has your application for renewal of your license or medical registration to practice medicine and surgery or dentistry ever been refused?		
23. A. Have you ever been charged with a violation of the Anti-Narcotic (Harrison) Act?		
B. Has your registration under this act ever been suspended or revoked or your application for registration denied?		
C. Have you ever been charged with violation of any state law pertaining to habit-forming drugs, narcotics, or intoxicating liquor?		

24. REMARKS -- Use this space and additional sheets, if necessary, to give any additional information in connection with your answers to the above questions.

PRIVACY INFORMATION

The Office of Personnel Management is authorized by section 1302 of Chapter 13 (Special Authority) and sections 3301 and 3304 of Chapter 33 (Examination, Certification, and Appointment) of Title 5 of the U.S. Code to collect the information on this form.

Executive Order 9397 (Numbering System for Federal Accounts Relating to Individual Persons) authorizes the collection of your Social Security Number (SSN). Your SSN is used to identify this form with your basic application. It may be used for the same purposes as stated on the application.

The information you provide will be used primarily to determine your qualifications for Federal employment. Other possible uses or disclosures of the information are:

1. To make requests for information about you from any source (e.g., former employers or schools), that would assist an agency in determining whether to hire you;
2. To refer your application to prospective Federal employees and, with your consent, to others (e.g., State and local governments) for possible employment;
3. To a Federal, State, or local agency for checking on violations of law or other lawful purposes in connection with hiring or retaining you on the job, or issuing you a security clearance;
4. To the courts when the Government is party to a suit; and
5. When lawfully required by Congress, the Office of Management and Budget, or the General Services Administration.

Providing the information requested on this form, including your SSN, is voluntary. However, failure to do so may result in your not receiving an accurate rating, which may hinder your chances for obtaining Federal employment.

ATTENTION -- THIS STATEMENT MUST BE SIGNED

Read the following paragraph carefully before signing this Statement

A false answer to any question in this Statement may be grounds for not employing you, or for dismissing you after you begin work, and may be punishable by fine or imprisonment (U.S. Code, Title 18, Sec. 1001). All statements are subject to investigation, including a check of your fingerprints, police records, and former employers. All the information you give will be considered in reviewing your Statement and is subject to Investigation.

CERTIFICATION	SIGNATURE (Sign in ink)	DATE SIGNED
I CERTIFY that all of the statements made in this Statement are true, complete, and correct to the best of my knowledge and belief, and are made in good faith.		